

# Implementation of the Henry J. Kaiser Family Foundation's Community Health Promotion Grant Program: A Process Evaluation

THOMAS M. WICKIZER, EDWARD WAGNER, ALLEN CHEADLE et al.\*

*University of Washington; Group Health Cooperative of Puget Sound*

COMMUNITY-BASED PROGRAMS FOR PREVENTING disease and promoting the health of whole populations rely on interventions like community-wide health education and screening, dissemination of information through the mass media, and actions to change laws or regulations that affect health. Over the past decade, large-scale trials have been conducted to evaluate this approach to prevention (Shea and Basch 1990a,b); many small-scale community health projects have been instituted as well to address local health concerns and needs through initiatives like the Planned Approach to Community Health (PATCH) (Nelson et al. 1987; Steckler et al. 1992) and the Community Chronic Disease Prevention (CCDP) programs (U.S. Department of Health and Human Services 1986). Between 1985 and 1991, more than 50 different community health promotion projects in 17 states were initiated through the PATCH program alone (Spears 1992).

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\**Coauthors of the article are* DAVID PEARSON, WILLIAM BEERY, JENNIFER MAESER, BRUCE PSATY, MICHAEL VONKORFF, THOMAS KOEPESELL, PAULA DIEHR, and EDWARD B. PERRIN.

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350 Main Street, Malden, MA 02148, USA, and 108 Cowley Road,  
Oxford OX4 1JF, UK.

Evaluations conducted to date have focused on outcomes; process has been largely neglected, which has led to a gap in knowledge about how programs are implemented and has hindered the development of useful treatment theories regarding the causal mechanisms underlying community health interventions (Lipsey 1990). Research conducted by Steckler and Goodman has contributed new insights to the field of community health promotion (Goodman and Steckler 1987, 1989; Steckler and Goodman 1989; Goodman, Steckler, and Hoover 1993), as it has highlighted the importance of several factors that lead to program success: community competency; depth of community involvement; level of organizational support provided by the sponsoring agencies; and the degree to which the organizational goals and mission of the program “fit” with those of the sponsoring agency.

## Background

In 1986, the Henry J. Kaiser Family Foundation started a major initiative to reduce risk factors in five areas: adolescent pregnancy; cancer; cardiovascular disease; injuries; and substance abuse (Tarlov et al. 1987). One of the programs funded under this initiative was the Community Health Promotion Grant Program (CHPGP) in the West, which is described in more detail in the next section. Its intent was to assist communities in developing health interventions in one or more of the targeted health areas listed above. Through this program, three-year grants of up to \$450,000 (with an option to renew an additional two years) were awarded to 11 western U.S. communities, including two states, four large urban areas (over 300,000 in population), three suburban/rural areas, and two Native American regions/reservations. The 11 sites were selected from a pool of 18 finalist applicant communities. Four of the 11 sites (an urban and a Native American site and the two state programs) were funded because of special merit. From the remaining 14 sites, seven were selected at random for the demonstration; the other seven sites were used as controls for an outcome evaluation (Wagner et al. 1991).

All 11 grants were renewed for an additional two years, and, with one exception, projects were funded at approximately the same level (\$150,000 per year) as before. Some projects had unexpended grant funds at the end of five years and were given no-cost extensions of up to one year. By July 1993, all program grant funds had been expended. In

addition to providing funding, the CHPGP furnished grantees with ongoing technical assistance through the Health Promotion Resource Center at Stanford University. Grantees also received some technical assistance from the foundation's staff and from outside consultants.

The foundation funded an independent evaluation of the program conducted by a team of researchers at the University of Washington and the Group Health Cooperative of Puget Sound. This evaluation had two major components: an outcome assessment (Wagner et al. 1991), designed to analyze the effects of the interventions on community health norms, environmental conditions, and individual behavior; and a process analysis (Wickizer et al. 1993), which was intended to document and analyze selected aspects of program implementation. We will summarize the most important results of the process analysis in this article. The major findings of the outcome evaluation, including a description of its research design, are reported elsewhere (Wagner et al. 1997).

Four areas that are central to the Kaiser Family Foundation's community health promotion strategy are examined:

1. level of intervention activity and extent of population exposure
2. activation of the community to encourage health promotion
3. leveraging of grant support through external funding
4. program institutionalization

## Methods

### *The Demonstration Program and Evaluation Setting*

The CHPGP represents a "bottom up" intervention approach. Although grantees had to operate within broad guidelines, they had great latitude in organizing their program and in developing intervention activities (Tarlov et al. 1987). Grantees had to meet three explicit requirements:

1. establish a coalition that encompassed a broad spectrum of community agencies and organizations
2. conduct a formal needs assessment
3. target for intervention one or more of the five health problems described above

Grantees could change health targets as well as add new ones. In fact, the hope was that the focus of their interventions would broaden as they gained experience. Earlier, Tarlov et al. (1987) described the foundation's initiative as follows: "We anticipate they [projects] will expand to other related problems and engage the entire community in an ongoing effort to reduce the burden of preventable disease." To accomplish this, project administrators were expected to broaden their resource base (i.e., to leverage their grant funds) by attracting outside support through fund raising, external grants, or in-kind donations, and to become institutionalized so they could continue to function as an ongoing community resource.

One requirement that was not formally spelled out at the outset of the program, but that the foundation program staff recognized as essential early on, was for participant communities to become "activated for" health promotion. Community activation as a health promotion strategy entails organized efforts to increase community awareness and to reach a consensus about health problems, coordinated planning of prevention and environmental change programs, interorganizational allocation of resources, and citizen involvement in these processes. To apply the typology of community organization described by Rothman (1970), community activation would be most closely associated with the social planning model, which emphasizes the pathways of organizational change and the strategies of rational planning to achieve the goals of change.

Programs using a community activation approach would typically seek to involve community leaders, citizen representatives, and health professionals acting through their organizational affiliations. These key players would focus on important community organizations, like schools and local health departments, that can offer access to target populations. Community activation depends on interorganizational coordination, which encompasses a broad spectrum of activities, ranging from infrequent informal contact between members of two organizations participating in a coalition to more frequent, formalized contact between members of organizations developing a joint program. We anticipated that the community coalition would include representatives of major community organizations and would serve as the primary catalyst for activation.

It should be apparent that the CHPGP was not intended to test a single, well-defined intervention model or behavioral change theory.

Rather, its purpose was to assist communities in establishing and sustaining organized, coordinated community-based initiatives to reduce identified health risk factors.

### *Data and Measures*

We obtained data for the analysis from several sources. Information on the communities and grantees was gathered from the original grant applications and through periodic progress reports completed by each grantee at six-month intervals during the demonstration. These same reports served as the data source on program exposure, external funding and in-kind donations, and community coalition activities. Additional, more detailed, coalition data were gathered through telephone interviews conducted as part of a special survey that was completed in early 1993. This survey, of 108 individuals who served on nine coalitions, gathered information on various areas of coalition organization and operations. Two of the 11 sites (an urban program and a Native American site) did not establish ongoing coalitions and were therefore not included in the survey.

Data on community activation were obtained through a key informant survey, which has been previously described in detail (Wickizer et al. 1993). In brief, this survey was completed through telephone interviews with key informants affiliated with various organizations in each of the intervention communities at three points in time: baseline and two- and four-year follow-up. Baseline interviews were conducted with 779 informants, and follow-up interviews took place with 652 and 525 informants at two years and four years, respectively. On each survey occasion, the response rate exceeded 90 percent. We intended to interview the same cohort of informants over time, but this was not always possible because some informants either moved out of the area or changed employment, and therefore could not report on the organization they initially represented. In some cases, the organization itself ceased operation. Where possible, we attempted to identify and interview replacement informants.

Information on institutionalization was obtained through telephone interviews with project directors and chairpersons of the community coalitions in late 1993 and early 1994.

Using these data sources, we constructed several sets of measures, both quantitative and qualitative, to describe the development and im-

plementation of the programs. The initial impetus that led to writing the grant proposal is described qualitatively, as are the primary interventions developed by the projects. The coalitions established by the programs are examined through the following indicators: number of active coalition members; percent of members who stated that their coalition had decision-making authority; percent of coalition members on subcommittees or task forces; number of coalition meetings per quarter; and number of hours spent per member per month on coalition and program business.

We examined the extent of external fund raising on the basis of three measures: total external funding; estimated value of in-kind donations/support; and the sum of these two measures as a percentage of CHPGP grant support.

To document the exposure of individuals in the target population to the program's interventions, we classified intervention activities into three broad categories representing high-, medium-, or low-intensity services. High-intensity services included individual prevention services like risk assessments, screenings, and counseling; medium-intensity services represented mainly health education classes; and low-intensity services consisted of activities like health fairs, drug- or alcohol-free social events, or peer modeling. (Media occasions [television, radio, and newspaper] are reported separately.) Within each category, the number of exposure occasions per 1,000 population is reported. Although it would have been preferable to derive and report unduplicated counts of the number of persons exposed to intervention activities, it was not feasible to do so.

We used three measures derived from responses to the key informant survey (Wickizer et al. 1993) to assess changes in activation. The first provided an index of organizational links established by the program. More specifically, it measured the percentage of organizations in the relevant health target area (e.g., substance abuse or adolescent pregnancy) that reported coordinating one or more activities with the program. The second represented the percentage of *pairs of organizations* within the relevant health target network that reported coordinating program activities. In the terminology of network analysis (Knoke and Kuklinski 1982), this measure is known as "network density" (Laumann and Pappi 1976; Burt 1980). The third measure was a composite activation score based upon key informant ratings of ten items representing different dimensions of activation. These items, rated on the

basis of five-point scales (1 = very weak; 5 = very strong), included community planning, program coordination, community leadership, service utilization, funding, program availability, program support, public awareness, matching of programs to community needs, and publicizing of programs. We combined each informant's ratings into a single score, weighting the ratings equally and averaging them across the items. Scale scores are the mean ratings of the items answered.

Interviews conducted to assess program institutionalization revealed considerable variation in the organization and post-grant operations of projects. For this reason, we documented program institutionalization qualitatively, focusing on four areas: organization; activities/staffing; funding; and coalition operations.

### *Analytic Approach*

Descriptive information pertaining to the above measures is presented for each site in a series of tables. To preserve confidentiality, we refer to the sites as A, B, C, and so on. Each of the tables is organized similarly, with the programs grouped into four strata according to the categories of suburban/rural, urban, Native American, or state. Included in the suburban/rural stratum are three sites, two located in California and one in Utah. The urban stratum comprises four sites, three located in California and one in Oregon. Within the third stratum, representing Native American reservations or regions, one site is in Alaska and the other is in Wyoming. The fourth stratum encompasses the two statewide programs. As noted earlier, four of the eleven sites were awarded program funding because of special merit, while the remaining seven were selected based on a stratified random sampling procedure (Wagner et al. 1991).

## Results

### *Program Intervention and Coalition Characteristics*

Table 1 presents information on program and target area characteristics. There was considerable variation among the eleven sites in these characteristics. The two Native American sites had less than 5,000 population. In contrast, two of the four urban sites had a total area population of more than half a million. Over 80 percent of the population was

TABLE 1  
Selected Target Area and Program Characteristics

Community <sup>a</sup>	Total area population <sup>b</sup> (target population)	% below poverty line	Two largest ethnic groups		Sponsoring agency	Health target area(s)	Primary target group(s)
			(1)	(2)			
Suburban/rural							
A#	340,417 (245,581)	31	White (70%)	Black (12%)	Health system agency	Cancer prevention	General adult population
B#	33,928 (3,485)	5	White (95%)	Hispanic (5%)	County medical health center	Substance abuse	Children and adolescents
C#	25,293 (2,753)	1	White (99%)	—	County health department	Substance abuse	Children and adolescents
Urban							
D	584,266 (39,563)	9	White (92%)	Black (3%)	HMO	Teen health	Adolescents
E#	723,959 (105,380)	42	White (58%)	Asian (22%)	County health department	Injury prevention	Elderly
F#	103,993 (7,337)	62	White (39%)	Black (35%)	Private nonprofit agency	Teen pregnancy	Black children and adolescents
G#	80,953 (80,953)	81	Hispanic (95%)	White (19%)	University	Cardiovascular disease; cancer prevention	Hispanic adult prevention



Native American							
H#	4,799 (4,799)	86	Native American (95%)	White (14%)	Native American regional cooperative	Substance abuse	Alaskan natives, all ages
I	4,149 (2,208)	87	Native American (85%)	White (13%)	County mental health center	Substance abuse	Native American adolescents
State programs							
J	786,690 (72,381)	6	White (94%)	Native American (5%)	Private nonprofit agency	Teen pregnancy	Adolescents
K	2,908,377 (2,908,377)	11	White (88%)	Hispanic (12%)	State health department	Multiple health practices	General population, all ages

<sup>a</sup># = site randomly selected.

<sup>b</sup>Total area population is the population within the target area defined in the project proposal. Target population refers to the population of the target group(s) within this area. For example, the total population of the geographic target area for site F is 103,993. The target group comprised 7,337 children and adolescents.

below the poverty line in three sites, including the two Native American reservations, and over 40 percent fell below the poverty line in two other inner-city urban sites. Improving the health of minority populations, which were often at high risk because of environmental and social circumstances, was an important goal of the demonstration. Of the eleven programs, five directed their intervention activities specifically at minority populations. Given the well-established link between poverty and poor health (Susser, Watson, and Hoper 1985; Patrick *et al.* 1988), these data suggest that large portions of the target populations in several sites faced serious health problems. Agencies sponsoring the projects included state and local health departments, mental health centers, health maintenance organizations (HMOs), and private, non-profit agencies. The eleven programs confronted various health problems: four targeted substance abuse; three dealt with teen pregnancy or teen health; two focused on cancer or cardiovascular disease; one was concerned with injury prevention; and one addressed multiple health problems. Six of the sites intervened specifically in concerns of children or adolescents.

Table 2 gives descriptions of the primary interventions developed to address each community's health problem(s) and highlights the health concern that provided the impetus for developing the proposal. For some sites, the major program impetus was a health crisis, often teen suicides related to substance abuse; for other sites the concern was about a more general health problem like cancer or cardiovascular disease. The two state programs developed their proposals as a culmination of planning that began earlier in response to well-documented health problems.

The programs developed a diverse set of interventions in response to these health problems. The most homogeneous were in sites focusing on adolescent health problems; these all created school-based programs that provided life-skills classes, peer-modeling activities, drug- or alcohol-free social events, or parenting classes. Sites focusing on adult health problems often established community screening or health education activities or developed programs to disseminate health-related information to the public, such as nutrition education campaigns in grocery stores. Although some sites developed media campaigns (e.g., radio or television public service announcements), this approach was not used widely. The interventions developed by the two state programs differed from those of other programs in their focus on health policy issues and on building capacity at the local level. To accomplish the latter, one

TABLE 2  
Program Impetus and Primary Interventions

Community <sup>a</sup>	Program impetus as described in proposal	Primary interventions
Suburban/rural		
A#	Concern about cancer risk within the county	<ul style="list-style-type: none"> <li>• Media campaign</li> <li>• Nutritional education campaign in grocery stores</li> <li>• Sting operations to reduce sale of tobacco to minors</li> <li>• Campaign to pass local ordinance banning cigarette vending machines</li> </ul>
B#	Five adolescent suicides	<ul style="list-style-type: none"> <li>• Parenting-skills training</li> <li>• Life-skills, sexuality, refusal-skills training</li> <li>• Peer leader/helper programs</li> <li>• Alcohol- and drug-free social events</li> </ul>
C#	Increase in drug- and alcohol-related incidents among students; one suicide attempt	<ul style="list-style-type: none"> <li>• School-based activities including life-skills classes, teacher training, alcohol- and drug-free social events, and peer leader activities</li> <li>• Family-based activities, including parenting classes, family annual conferences, and pledge program for alcohol-free homes</li> </ul>
Urban		
D	Concern about teen suicide and gang activity as major issues affecting adolescent health	<ul style="list-style-type: none"> <li>• Establish student-directed program boards in schools to plan and develop interventions, including peer assistance and mental health initiatives</li> </ul>
E#	Concern about unintentional injuries as a public health problem among the elderly, affecting their ability to live independently at home	<ul style="list-style-type: none"> <li>• Home modifications for environmental safety</li> <li>• Review of prescription medications</li> <li>• Public advocacy of issues related to health and welfare of elderly</li> </ul>
F#	Identification by black health advocacy group of adolescent pregnancy as a major health concern in the black community	<ul style="list-style-type: none"> <li>• School curricula health initiatives</li> <li>• Church-based health initiatives related to adolescent pregnancy and teen health</li> <li>• Parental training classes</li> <li>• Community education and public awareness initiatives</li> <li>• Media campaign</li> </ul>

(continued)

TABLE 2 *Continued*

Community	Program impetus as described in proposal	Primary interventions
G#	Concern about nutrition problems in local Hispanic community and the increased risk of cancer and cardiovascular disease	<ul style="list-style-type: none"> <li>• Community health screenings</li> <li>• School-based nutrition education</li> <li>• Grocery store interventions</li> <li>• Community nutrition classes</li> </ul>
Native American		
H#	High rates of teenage pregnancy, suicide (young males), and accidents in the Alaskan Native population	<ul style="list-style-type: none"> <li>• Village health educator program to place allied health personnel in remote villages</li> <li>• Resource center to distribute health education materials</li> <li>• Assist school districts in developing and incorporating health teaching into the curricula</li> </ul>
I	Increase in teenage suicide	<ul style="list-style-type: none"> <li>• School-based youth activities, including social- and refusal-skills training, peer counseling programs, and drug-free activities</li> <li>• Family resource center for parent/youth education training</li> <li>• Community education activities to promote awareness of substance abuse problems, to establish codes regarding control of alcohol/drug abuse, and to improve law enforcement</li> </ul>
State program		
J	Governor's conference identifying adolescent pregnancy as a major state health concern	<ul style="list-style-type: none"> <li>• Technical support and funding to develop local coalitions and interventions</li> <li>• Activities to promote public awareness of adolescent pregnancy and health initiatives</li> <li>• Policy/advocacy efforts to strengthen adolescent pregnancy prevention action</li> </ul>
K	Statewide conference identifying major preventable causes of illness among state residents	<ul style="list-style-type: none"> <li>• Mini-grant program to provide small grants (&lt;\$10,000) to local communities for health promotion projects</li> <li>• Needs assessment protocol designed to aid local communities in planning and developing health promotion programs</li> <li>• Work site exercise program</li> </ul>

<sup>a</sup># = site randomly selected

state program (K) developed a mini-grant program to fund local health promotion projects; the other (J) funded local campaigns to combat teen pregnancy.

Community coalition building was a requirement of the CHPGP in order to create a focus for planning and coordinating health projects. Table 3 presents information on selected characteristics of the coalitions that developed at nine sites. Two sites, an urban community (D) and a Native American reservation (H), did not establish coalitions. The urban site made a conscious decision not to develop a community coalition; instead, it established school councils to coordinate program activities. The Native American site encountered problems early on and was unable to establish a coalition that functioned beyond the initial stage of the program.

TABLE 3  
Selected Characteristics of Program Coalitions

Community	Mean number of active members during grant period	Percent of members perceiving coalition had decision-making authority	Percent of members on subcommittee or task force	Meetings per quarter	Number of hours per member per month
Suburban/rural <sup>a</sup>					
A#	23	46	73	1.5	4.4
B#	26	77	73	3.0	7.4
C#	23	60	30	2.1	5.1
Urban					
D <sup>b</sup>	—	—	—	—	—
E#	38	23	46	0.9	4.3
F#	14	0.0	43	1.5	2.5
G#	18	11	33	1.8	4.4
Native American					
H#	—	—	—	—	—
I	10	27	27	2.7	6.1
State programs					
J	31	36	93	3.0	10.1
K	13	55	64	4.2	6.5
Overall	22	37	54	2.3	5.7

<sup>a</sup># = site randomly selected.

<sup>b</sup>Coalition did not operate at this site. See discussion in text.

There was considerable variability, both within and across strata, in coalition size, organizational structure, and activity level. The average coalition had 22 active members at any one time, but three had fewer than 15 members and two had over 30 members. The coalitions in the suburban/rural stratum had more decision-making authority than other coalitions and were more formally structured, as indicated by the use of subcommittees and task forces. Coalitions developed by urban sites tended to be more advisory and less structured. The two state programs present a mixed picture. One coalition (site J) was highly structured, but its members had little decision-making authority. The other coalition (site K) was less structured, but its members had more decision-making authority over program matters. Although little is known about the effects of organizational structure on community health coalitions specifically, studies of organizational behavior suggest that formally organized coalitions may be more effective in achieving their objectives (Litwak and Hylton 1962; Rogers and Whetten 1982).

The coalitions met approximately twice per quarter. On average, members spent almost six hours per month attending coalition meetings or conducting program-related business. The most active coalitions were found in the two state programs, perhaps reflecting both the larger scope and greater organizational complexity of these programs and the fact that they had to meet to review and award mini-grants. The coalition of a rural program (B) was also highly active, with members devoting, on average, almost a full day per month to program-related matters. This same coalition was highly structured and afforded its members more decision-making authority than most of the others. The program director at this site was an energetic leader who clearly understood the importance of developing broad-based support for the program through the coalition, thereby encouraging the community's active participation in school-based substance abuse prevention initiatives.

### *External Funding and Program Exposure*

It was expected that programs would secure outside funding or in-kind donations approximately equal in value to the Kaiser Family Foundation grant (\$150,000 per year) to help support their activities. Data gathered by the evaluation suggest that most programs were able to generate substantial outside funding. The average program raised ap-

proximately \$227,000 in external funding and an additional \$151,000 from in-kind donations or support during the grant period, which represented 58 percent of the Kaiser Family Foundation grant. The two state programs were the most successful in generating outside support (over \$600,000), which could reflect several factors, including greater program support provided by state government, greater visibility or credibility, better grant writing, or better access to funding information. Another program that generated substantial outside support was an urban, school-based program (D), as it received significant in-kind support from the schools where its interventions were based. With one exception, all of the other programs were able to generate support representing at least 25 percent of the CHPGP grant.

The programs developed a highly diverse set of interventions tailored to meet local health needs and conditions. Although no explicit strategy was prescribed for selecting or delivering interventions, sites were encouraged to develop broad-based interventions that would maximize the extent of exposure within the target population. Table 4 summarizes information on program exposure, measured as exposure occasions per 1,000 target population. Services and activities developed by the programs were classified into three categories according to intensity (high-, medium-, and low-intensity services). It was not possible to gather reliable data on the number of persons exposed to media messages. Therefore, media occasions are reported separately as counts.

The data reveal different patterns of intervention activities and related exposure levels. Programs using medium- or low-intensity interventions achieved, on average, higher exposure rates. School-based programs (sites B, C, D, F, and I) that developed medium- or low-intensity services, like classes or drug- and alcohol-free social events or peer modeling, achieved the highest exposure levels. In one Native American site (I), the reported exposure level (exposure occasions per 1,000 target population) exceeded 1,200. In part, the high exposure rates achieved by some of the school-based programs reflect the small population bases used to calculate the rates (see table 1). Two suburban/rural sites (A and B) relied heavily on the media to disseminate health information to the target groups, sponsoring over 300 media occasions (television, radio, or newspaper messages) per year (including health information messages presented by the program itself). These programs, however, were the exception, as most sites did not turn extensively to the media to disseminate health information. High-intensity

TABLE 4  
Occasions of Program Exposure per 1,000 Population in Target Area<sup>a</sup>

Community	Intervention intensity <sup>b</sup>			Media occasions <sup>c</sup>
	High	Medium	Low	
Suburban/rural <sup>d</sup>				
A#	<5	<5	<5	325
B#	40	880	410	320
C#	40	210	430	25
Urban				
D	15	125	165	<5
E#	<5	15	0	<5
F#	10	450	85	135
G#	20	10	<5	20
Native American				
H#	<5	30	40	90
I	25	1,215	1,250	20
State programs				
J	5	50	45	90
K	<5	<5	0	60
Overall	15	275	225	100

<sup>a</sup>Data do not represent unduplicated counts of persons exposed to interventions.

<sup>b</sup>High-intensity services include counseling, home repair, safety inspection, risk assessment, screenings, and teacher training activities. Medium-intensity services most often consist of classes. Low-intensity services include activities like peer modeling, food tasting, health fairs, and drug- and alcohol-free social events.

<sup>c</sup>It was not possible to obtain reliable data on the number of persons exposed to media. The figures shown represent the mean annual number of media occasions (TV, radio, newspaper), including presentation of health promotion information by the program.

<sup>d</sup># = site randomly selected.

services, like counseling, risk assessment, or home repair, resulted in lower levels of exposure. The nature of these services was such that they were more time intensive and individually focused.

### *Activation and Institutionalization*

Table 5 summarizes information on changes in activation. Whereas some sites did show evidence of positive changes, the overall pattern is one of mixed results, with many sites showing little change in activation from baseline to four-year follow-up. Two sites (A and I) showed limited evidence to suggest any positive change. One rural California school-



TABLE 5  
Change in Coordination and Activation

Community	Degree of coordination with program <sup>a</sup>		Network coordination <sup>b</sup>		Information ratings of activation <sup>c</sup>	
	Baseline (%)	Four-year follow-up (%)	Baseline intervention sites <sup>d</sup> (%)	Change intervention sites <sup>d</sup> (4-year follow-up minus baseline) (%)	Baseline	Change (4-year follow-up minus baseline)
Suburban/rural <sup>e</sup>						
A#	33	44	20.0	2.2	35.5	6.3
B#	88	100	55.6	19.4	34.3	3.8
C#	86	71	48.1	-6.3	33.2	-1.4
Urban						
D	36	18	28.8	-6.1	29.7	-1.1
E#	100	67	42.9	-9.5	36.0	-9.1
F#	45	64	21.2	1.5	27.8	2.3
G#	67	50	33.3	-4.8	32.5	-3.2
Native American						
H#	75	63	50.0	-22.2	29.6	1.9
I	40	60	23.6	3.6	28.8	-4.4
State programs						
J	63	88	41.7	-13.9	30.9	-1.8
K	100	83	57.1	-9.5	32.9	2.9
Overall	67	64	38.4	-4.1	31.9	-0.3

<sup>a</sup>The percentage of organizations in the program's health target network that reported coordinating program activities with it.

<sup>b</sup>Figures represent the percentage of pairs of organizations in the health target network that coordinate program activities.

<sup>c</sup>Figures represent the average rating of activation in 10 different areas, based on a 5-point scale, where 1 = very weak, 3 = neutral, and 5 = very strong. Scale values were multiplied by 10 to yield scores ranging from 10 to 50.

<sup>d</sup>Control sites had a mean value at baseline of 39.3. The mean change in network coordination from baseline to follow-up was 0.09.

<sup>e</sup># = site randomly selected.

based program (B) showed notable positive change in both program and network coordination but only modestly improved its level of activation based on the key informants' ratings. At four-year follow-up, every organization within this site's health target network (substance abuse) was coordinating activities in some way with the program. The level of network coordination—that is, between other organizations active in

substance abuse prevention or treatment—also increased significantly. Whereas 57 percent of the pairs of organizations coordinated program activities at baseline, by four-year follow-up 76 percent were actively coordinating one or more program functions.

The goal was for the programs to become institutionalized and continue to operate in some fashion after the demonstration ended, although no specific form of institutionalization was prescribed. In general, the foundation hoped that significant intervention activities would be maintained, although not necessarily by the program itself, and that the community coalition would continue to function and to support planning and coordination of health promotion and prevention activities. Table 6 summarizes information on program institutionalization gathered through interviews with project directors and coalition chairpersons. These interviews represent the program status as of late 1993 and early 1994, approximately six to twelve months after CHPGP funds had been expended.

The form and level of program institutionalization varied considerably among the sites. Sites within the suburban/rural and urban strata were less successful than others, although some in these two categories continued important program functions and intervention activities. The formal programs and coalitions at sites A and C were terminated, but selected prevention activities were continued. At site A, tobacco prevention activities were continued under a new project organized by the county; at site C, limited school-based activities and community parenting classes were maintained on an informal basis. The program at site B continued to operate under a reorganized structure as part of a county agency, and its coalition remained active, meeting on a regular basis.

At three urban sites (D, E, and G), the programs and coalitions were terminated, but at site G school- and community-based nutritional intervention activities continued under a new project that was established with a large federal grant. Some intervention activities established at site E were shifted to a city government agency and continued on a very limited basis. At site F the coalition disbanded, but the program targeting teen pregnancy problems among black adolescents continued to operate, although on a limited basis because of reduced funding.

Program institutionalization occurred on a more formal level and on a broader scale in the remaining four sites. The programs continued to

TABLE 6  
Summary of Program Institutionalization

Community <sup>a</sup>	Program organization	Activities/staffing	Funding	Coalition
Suburban/rural				
A#	<ul style="list-style-type: none"> <li>• Program terminated</li> <li>• Some prevention activities continued under new county-sponsored project</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco prevention activities continued under new project</li> <li>• Staff includes 3.5 full-time equivalent (FTE) personnel</li> </ul>	<ul style="list-style-type: none"> <li>• Proposition 99 funds</li> </ul>	<ul style="list-style-type: none"> <li>• Disbanded</li> </ul>
B#	<ul style="list-style-type: none"> <li>• Program continued and reorganized under county</li> </ul>	<ul style="list-style-type: none"> <li>• Activities continue but at reduced level because of restricted funding</li> <li>• Greater use of volunteers</li> <li>• Program staff reduced to 0.5 FTE</li> </ul>	<ul style="list-style-type: none"> <li>• Small private grant and limited fund raising initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• Continues to meet regularly</li> </ul>
C#	<ul style="list-style-type: none"> <li>• Program terminated</li> </ul>	<ul style="list-style-type: none"> <li>• Limited activities maintained by schools and one local mental health agency</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Disbanded</li> </ul>
Urban				
D	<ul style="list-style-type: none"> <li>• Program terminated</li> <li>• Program staff attempting to start new nonprofit organization to provide training and consultation to local schools</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Not established at site</li> </ul>
E#	<ul style="list-style-type: none"> <li>• Program terminated</li> <li>• Some program functions absorbed by a city government unit</li> </ul>	<ul style="list-style-type: none"> <li>• Limited activities provided by volunteers under the direction of city agency</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Disbanded</li> </ul>

(continued)

TABLE 6 *Continued*

Community	Program organization	Activities/staffing	Funding	Coalition
F#	<ul style="list-style-type: none"> <li>• Program continued and reorganized as a nonprofit organization</li> </ul>	<ul style="list-style-type: none"> <li>• Scope of activities limited because of restricted funding</li> <li>• Functions performed mainly by volunteers, one full-time paid staff</li> </ul>	<ul style="list-style-type: none"> <li>• Limited support provided by state and local grants, United Way, and fund raising</li> </ul>	<ul style="list-style-type: none"> <li>• Disbanded</li> </ul>
G#	<ul style="list-style-type: none"> <li>• Program terminated</li> <li>• Selected activities continued under reorganized project</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly community screening for cholesterol, blood pressure, and weight provided</li> <li>• School-based nutritional activities continued</li> </ul>	<ul style="list-style-type: none"> <li>• National Cancer Institute 5-year grant and smaller Heart Association grant</li> </ul>	<ul style="list-style-type: none"> <li>• Disbanded</li> </ul>
Native American				
H#	<ul style="list-style-type: none"> <li>• Program continued under same organizational sponsorship</li> </ul>	<ul style="list-style-type: none"> <li>• Same mix of activities provided at reduced level because of restricted funding</li> </ul>	<ul style="list-style-type: none"> <li>• Support provided by private grants and by state and local grants</li> </ul>	<ul style="list-style-type: none"> <li>• Not established at this site</li> </ul>
I	<ul style="list-style-type: none"> <li>• Program continues to operate but reorganized as independent, private nonprofit organization</li> </ul>	<ul style="list-style-type: none"> <li>• Same mix of activities provided at reduced level because of restricted funding</li> </ul>	<ul style="list-style-type: none"> <li>• Support provided by state and local grants</li> </ul>	<ul style="list-style-type: none"> <li>• Continues to meet regularly</li> </ul>
State programs				
J	<ul style="list-style-type: none"> <li>• Program continued and reorganized as independent, private nonprofit organization</li> </ul>	<ul style="list-style-type: none"> <li>• Program continues to offer same mix and scope activities</li> <li>• Nine FTE paid staff</li> </ul>	<ul style="list-style-type: none"> <li>• Support provided by large private grant and other grants</li> </ul>	<ul style="list-style-type: none"> <li>• Continues to meet regularly</li> </ul>
K	<ul style="list-style-type: none"> <li>• Program continued under same organizational sponsorship</li> </ul>	<ul style="list-style-type: none"> <li>• Same mix and level activities provided</li> <li>• Same staff levels (4.5 paid FTE)</li> </ul>	<ul style="list-style-type: none"> <li>• Core funding from state health department and other funding from a mix of private and public grants</li> </ul>	<ul style="list-style-type: none"> <li>• Continues to meet regularly</li> </ul>

<sup>a</sup># = site randomly selected.

function at both Native American sites (H and I). The program at site H encountered serious organizational and administrative problems throughout much of the demonstration, but it survived them and later became more stable when a top-level change in leadership occurred at the sponsoring agency. This program met critical health needs among the Inuit population of Alaska, which may account for its survival in a hostile organizational environment. The program at site I was reorganized as an independent, nonprofit agency offering needed substance abuse prevention services through the schools on a Native American reservation. The two state programs (J and K) and their coalitions continued to maintain an active presence in their respective areas. The program at site J obtained a large grant from another private foundation during the latter phase of the demonstration and was thus able to expand its scope of activities and even to add new staff. However, this program was unable to secure a stable funding base from state sources, and its need to rely on short-term grants created uncertainty about its future. In contrast, the other state program (K) was able to secure core funding from the state health department and thus achieved critical financial stability. This program was also fortunate to have close ties with a large private local foundation, which was an important funding source. The coalition established at this site remained active, and it continued to help plan and coordinate health promotion activities in the state.

## Discussion

In this article, we have documented the experience of 11 western communities that participated in the Kaiser Family Foundation's Community Health Promotion Grant Program in the West. Unlike many other community prevention trials, which have had prescribed, well-defined intervention protocols designed by outside experts, this demonstration gave communities broad latitude to develop their own action plans and health promotion activities. A notable aspect of this strategy was the notion of communities becoming actively involved in promoting health.

The 11 communities involved in the CHPGP confronted different health problems and responded by developing a broad array of activities and services. A significant level of program exposure was achieved among the target groups at a number of sites, in particular the school-based sites that concentrated on combating substance abuse and teen preg-

nancy. It was not feasible to assess systematically the quality of these intervention activities. Our impression, based largely on site visits conducted by research team members, is that the quality was variable: some programs developed or borrowed high-quality, scientifically grounded interventions; others relied on interventions whose quality or relevance was less certain. Unfortunately, no "gold standard" exists for judging the quality of community health interventions, and disagreement persists, even among experts, about their effectiveness.

Programs were able to leverage their grants by obtaining outside support. Many increased their resource base by 50 percent or more. The two state programs were particularly successful in attracting financial backing. While clearly important in helping programs develop and sustain their intervention activities during the demonstration period, the ability to leverage grant funds did not necessarily enhance the prospects for successful program institutionalization, as evidenced by the experience of several sites, particularly C, D, and E.

Activating the community for health promotion proved to be a largely unfulfilled goal of the CHPGP. Only one rural program (B) showed consistent, strong evidence of activation; two others (A and I) showed some evidence. Measuring changes over time at a community level in a complex phenomenon like activation poses daunting methodological challenges. Studies have treated community organization processes largely as a black box, so the literature offered little guidance to assist us in designing activation measures or developing analytic approaches. Because our notion of activation focused attention on interorganizational behavior, we developed measures and analytic techniques that allowed us to examine change in coordinating activities at the level of the organization. It is possible that our measures missed the mark and failed to detect changes that did occur. Other considerations, however, may be more important in explaining our results.

Community activation has strong theoretical appeal as a strategy for implementing community health promotion programs (Syme 1976; Rose 1981; Wallack et al. 1985). However, there was little understanding of how the goal of activation was to be achieved on a practical level. Moreover, it is not obvious that its importance was conveyed to CHPGP programs with sufficient clarity to enable them to organize their resources effectively toward the pursuit of this objective. Instead, programs tended to concentrate on the more immediate concerns of developing and carrying out intervention activities to reduce health

risks among the target groups. These efforts were concrete, visible, and easily quantified. In contrast, community activation was a less visible, more ephemeral process whose potential benefits were more distal in nature. These considerations may have reduced the incentives of programs to expend time and scarce resources on encouraging activation. The limited change observed in activation could reflect the fact that, with one or two exceptions, sites did not pursue this objective in a sustained fashion.

Another explanation stems from the inherent problems that arise when planned interventions attempt to change interorganizational behavior. Under the best of circumstances, activating a community is likely to prove difficult because it requires broad-based coordination among organizations and the development of action agendas that will not reflect the priorities of all organizations or groups. In short, it requires a willingness on the part of organizations to give up valued autonomy (Van de Ven 1976; Van de Ven and Ferry 1980). Our findings may, in part, reflect the reluctance of community organizations and groups to embrace efforts by the programs and coalitions to foster closer coordination and cooperation.

The foundation hoped that institutionalizing the program or coalition would strengthen the community's capacity to address ongoing health problems and needs. In eight of the eleven sites this outcome was at least partially achieved, particularly in three of the sites (F, H, and I), where the program addressed critical health problems of high-risk Native American or black populations. But sustaining viable coalitions proved to be more difficult. Of the nine coalitions established during the grant period, four remained active after the demonstration. This, in part, reflects the inherent organizational problems that coalitions confront (Van de Ven and Ferry 1980), particularly those that seek to foster closer coordination and cooperation among diverse groups. Organizational autonomy is always highly valued, and coalitions may, in the pursuit of their objectives, directly or indirectly compromise this autonomy. Should this happen, members' commitment to the coalition may diminish, and its viability may be jeopardized. In addition, over time other pressing problems surfaced, such as urban violence, that absorbed the energy of some communities, making it difficult to maintain the coalition's interest in promoting health. At other sites, there was a general feeling that the coalition had achieved its essential purpose and was therefore no longer needed.

The results of this process analysis have a number of implications for research, policy, and the field of practice. First, there is a clear and pressing need for treatment theories (Lipsey 1990) to apply to evaluation, policy making, and intervention design. Because of their ability to target health risk factors affecting large segments of the population through broad-based interventions, community health promotion programs have considerable potential to improve health (Kotke *et al.* 1985; Bracht 1990). Achieving this potential will require a deeper understanding of community processes and the formulation of testable treatment theories that explain the links between program inputs, outputs, and outcomes.

To date, far too little attention has been given to this issue. Green and Kreuter (1993) and Barnett (1997) have noted the need to rethink some of the basic, long-standing notions of community organization as a strategy for implementing community health interventions and to refine current approaches. We agree, but we would emphasize two additional points:

1. A modest investment by funding agencies in developing and testing treatment theories of community processes may pay large dividends.
2. There is a need for genuine collaboration between the research and practice communities to advance knowledge of how community organization principles can best be applied to address contemporary health problems.

Our findings highlight the importance of several factors for both policy makers and practitioners to consider. The experience of the sites involved in the CHPGP underscores the importance of strong organizational and program support from the sponsoring organization, which partially depends upon the fit between the goals of the program and the mission and orientation of the sponsoring organization. Where this support was lacking, programs had an uphill struggle. For example, the program in site C was sponsored by a small rural county health department that did not consider health promotion to be a priority and therefore did not provide the leadership or support for the program that was needed at critical junctures. Not surprisingly, the program at this site did not become institutionalized and continue to operate after the CHPGP ended. In contrast, at another rural site (B), as well as at a state program



site (K), the fit between the program's goals and the orientation and mission of the sponsoring organization was much better. At both sites, the programs benefited significantly from organizational and programmatic support provided by the sponsoring agency. The programs at both of these sites also became institutionalized.

Despite the infusion of resources provided through demonstration and other external sources, only one site (K) was able to achieve any stable funding to support ongoing activities. The widespread practice of supporting community health initiatives through short-term grants almost guarantees programmatic and organizational instability and works counter to the goal of institutionalizing community prevention programs and activities. New resource allocation mechanisms must be developed to provide more stable long-term funding for community health initiatives.

The community remains an important focus of attention for identifying and addressing many problems that affect health and quality of life. The Kaiser Family Foundation's Community Health Promotion Grant Program in the West represented an ambitious effort to assist communities in improving their ability to do so. Future community efforts should benefit from this experience by using it as a resource to devise better strategies for creating and sustaining health promotion programs.

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*Address correspondence to:* Thomas Wickizer, PhD, Department of Health Services, Box 357660, University of Washington, Seattle, WA 98195-7660.